



Disenrollment Instructions:

If you wish to disenroll from *Group MedicareBlue Rx*, please carefully read and complete all sections on this form. Notify your employer or union contact of your intent to disenroll before signing and dating the form. Mail completed form to: *Group MedicareBlue Rx*, P.O. Box 7029, Lawrence, KS 66044. For information about disenrolling, call 1-877-838-3827 Monday-Friday, 7:00 a.m. to 7:00 p.m. Central Time; 6:00 a.m. to 6:00 p.m. Mountain Time. TTY/TDD users should call 1-800-693-3816. For information about plans in your area, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2084.

Member Information (*Please print your name and address below*):

Group Name: _____ Group Number: _____
Full Name (Last, First, MI): _____ Gender: ☐ Male ☐ Female
Address: _____
City: _____ State: _____ Zip: _____
County: _____ Home Phone: _____ Date of Birth: _____
Social Security #: (optional) _____ Medicare Claim (ID) #: _____

By completing this disenrollment request, I agree to the following:

Group MedicareBlue Rx will notify me of my disenrollment date after they receive this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at *Group MedicareBlue Rx* network pharmacies in order to receive my prescription benefit. I understand that there are limited times in which I will be able to join other Medicare Advantage or Medicare prescription drug plans, unless I qualify for special circumstances.

I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I do not enroll in another Medicare Prescription Drug Plan or a Medicare Advantage with a Prescription Drug Plan at this time, or have other coverage as good as Medicare, I may have to pay a penalty for this coverage in the future.

Requested disenrollment date: _____

Member Signature: _____ Date: _____

Authorized Representative Signature*: _____ Date: _____

Authorized Representative Name (Print): _____ Phone #: _____

Authorized Representative Address: _____

Relationship to Member: _____

* If applicant is unable to sign, a court-appointed Authorized Representative, person with Durable Power of Attorney for Health Care (DPAHC), or person authorized by state law must sign above. By signing, the authorized representative certifies that he or she is authorized under state law to complete this disenrollment and that documentation of this authority is available upon request by *Group MedicareBlue Rx* or by Medicare.

Please ☒ mark the box ☐ next to the reason(s) that applies to why you are disenrolling from Medicare Prescription Drug Coverage:

- ☐ Due to loss of Medicare
☐ I no longer live within the service area
☐ Enrolled in another Medicare Prescription Drug Plan: Enrollment Date _____
☐ I have other coverage equal to the Medicare Prescription Drug Coverage: Enrollment Date _____
☐ Other (Please specify): _____